UNITED CONCORDIA

TRICARE Dental Program

ENROLLMENT/CHANGE FORM

- ❑ New Enrollment/Re-enrollment *(complete entire form)*
- ❑ Add Family Member *(complete sections A, B, C and F)*
- ❑ Cancel Enrollment *(complete sections A, D and F)*
- ❑ Change Address/Telephone # *(complete sections A and F)*
- ❑ Cancel Individual Family Member *(complete sections A, B, and F)*

❑ CONUS ❑ OCONUS	❑ Active Duty ❑ SELRES ❑ IRR

NOTE: Incomplete information on this form will delay your enrollment.

SECTION A

Sponsor Social Security Number	Sponsor Name (Last, First, Middle Initial)			Date of Birth (MM/DD/YY)	Sex ❑ M ❑ F
Home Address				Home Phone ( )	
City	State	Zip Code	Country	E-mail Address	
Please indicate if you intend to remain in the service for at least 12 months ❑ Yes ❑ No If No, you will not be enrolled. *(See Section A on reverse side for "Notice of Intent".)*				Rank	Branch of Service

SECTION B

1. If you are a Reserve Sponsor, whom do you want to enroll? ❑ Sponsor only ❑ Reserve family only ❑ Reserve Sponsor and Family

PLEASE LIST ALL FAMILY MEMBERS TO BE COVERED BY THIS ENROLLMENT.

Last Name	First Name	MI	Sex	Date of Birth MM / DD / YY	Check if Geographically Separated	OCONUS ('O') CONUS ('C')	Address (if different than Sponsor's)
Spouse				/ /			
Family Member				/ /			
Family Member				/ /			
Family Member				/ /			
Family Member				/ /			

Please add additional family member(s) on a separate sheet and attach to the enrollment form.

SECTION C

Important: 1. Do you or your family member(s) have other Dental Coverage? ❑ Yes ❑ No

If your answer to the above question is yes, please complete the following information.

Policy Holder	Insurance Company	Policy Number

Please list family members covered under this policy:

2. Is your spouse a Uniformed Service member? ❑ Yes ❑ No If yes, spouse's SSN and Branch of Service

SECTION D

Cancel Reason _____ (*see Section D on reverse side*) If other, please explain _____

SECTION E

Amount of *Initial* Payment (*see Section E on reverse side*)	Method of *Initial* Payment ❑ Check or Money order ❑ Visa ❑ Master Card
Credit Card #	Expiration Date
Name on Credit Card	Authorized Signature

SECTION F

This is my application for coverage, or change to coverage, under the TRICARE Dental Program. I authorize monthly deductions of required premiums from my earnings if my coverage and pay status permit payroll deduction. I understand and agree that IRR sponsors and Selected Reserve and IRR family members will be billed directly for the cost of coverage. I understand that enrollment is subject to verification of eligibility and receipt of one month's premium payment. For applications received by the 20th of each month, coverage will become effective the first day of the next month. For applications received after the 20th day of the month, coverage may not become effective until the first day of the second month.

Sponsor's Signature: _____ Date: _____

Because personal information is being requested from you, we are required by the Privacy Act of 1974, to notify you of the following: This information is requested under the authority of Chapter 55, Title 10, United States Code, Section 1076a. The information will be used to determine eligibility for enrollment in the TRICARE Dental Program (TDP). Disclosure is voluntary, however, failure to provide all information may delay or prevent enrollment in the TDP.

Instructions for completion of form on back.

Most of the TDP Enrollment Form is self-explanatory; however, there are certain fields to which special attention should be paid:

Definitions: CONUS - Continental United States. The area including the 50 United States, the District of Columbia, Guam, Puerto Rico, and the US Virgin Islands.

OCONUS - Outside the Continental United States

Section A: All information in this section is relevant to the Sponsor.

Notice of Intent - The TRICARE Dental Program has a mandatory 12 month initial enrollment period. If your Expiration of Term of Service (ETS) date is less than 12 months you are not eligible for the TRICARE Dental Program unless you intend to continue your service commitment for at least 12 months. This service commitment is calculated based on the time remaining in your current status (Active Duty, Selected Reserve or IRR) plus any uninterrupted combination thereof. By applying for this program you are agreeing to a minimum 12 month enrollment. If you intend to remain in the service for at least 12 months, please check yes.

Section B: All information in this section is relevant to the family member(s).

1. If you are a Reservist please indicate whom you want to enroll. For spouse and/or each family member who is to be enrolled in the TDP, please list name, sex, date of birth, geographically separated (check if the family member you are enrolling is geographically separated), indicate 'O' (for OCONUS) or 'C' (for CONUS) and address (if different than Sponsor's). If you are enrolling more than four family members please list additional members on a separate sheet and attach.

Section C: All information in this section pertains to other dental insurance.

2. If this is a joint service marriage, please check yes and list spouse's SSN and branch of service.

Section D: Please indicate (with a value listed below) the reason for cancellation.

G - Transfer to duty station where space available dental care is readily available in the Military Dental Treatment Facility

J - Moved to an OCONUS location

N - Voluntary disenrollment by Sponsor

O - Voluntary disenrollment by family member (Sponsor signature required)

P - Dissatisfied with program after 12 months mandatory enrollment period is completed

99 - Other reason not listed. Please explain in the space provided

Section E: Initial payment of one month's premium payment must be sent with the completed enrollment form in order to process your application. Please include one check or money order for all enrollments. (i.e. If a Reservist is enrolling self and family, only one check should be sent for both initial payments.) **Please include the Sponsor's SSN on the memo portion of the check or money order**. You will be charged a processing fee of $20.00 for any check returned due to insufficient funds. Subsequent monthly payments will be either deducted from your military pay account or billed directly. Other available options are: automatic withdrawal from your checking account or a charge to your credit card. Information regarding initial payments can also be accessed via United Concordia's website at www.ucci.com.

Monthly Premiums

	Active Duty		Selected Reserve				IRR			
	Single Premium (one family member)	Family Premium (more than one family member)	Sponsor Only	Single Premium (one family member-excluding Sponsor)	Family Premium (more than one family member-excluding Sponsor)	Sponsor & Family Premium*	Sponsor Only	Single Premium (one family member-excluding Sponsor)	Family Premium (more than one family member-excluding Sponsor)	Sponsor & Family Premium*
Feb 1, 2001 - Jan 31, 2002	$7.63	$19.08	$7.63	$19.08	$47.69	$55.32	$19.08	$19.08	$47.69	$66.77
Feb 1, 2002 - Jan 31, 2003	$7.90	$19.74	$7.90	$19.75	$49.36	$57.26	$19.75	$19.75	$49.36	$69.11
Feb 1, 2003 - Jan 31, 2004	$8.14	$20.35	$8.14	$20.35	$50.88	$59.02	$20.35	$20.35	$50.88	$71.23

* If both the sponsor and a single family member are enrolling, the premium due is the total of the Sponsor only and the single premium.

Section F: Enrollment/Change form cannot be processed without Sponsor's signature.

For help completing the enrollment form, call:

1-888-622-2256

Send enrollment forms with payments to:

United Concordia/TDP
Box 8500-5945
Philadelphia, PA 19178-5945

For all other enrollment changes and correspondence:

United Concordia
TDP Enrollment and Billing
PO Box 69426
Harrisburg, PA 17106-9426